DEPARTMENT OF HEALTH & FAMILY SERVICES
Division of Public Health
DPH 42001 (04/01)

TB SUSPECT CASE DATA

Client information is confidential under Wis. Stat. 146.82(1)

STATE OF WISCONSIN
Bureau of Communicable Diseases
ss. 252.05, Wis. Stats.

FOR INTERNAL USE ONLY: ☐ IN TIMS

Date Local Health Department Contacted (mm/dd/yyyy)	Referral Source	Referral Telephone No. ( )	Reported To LHD Within 24 Hrs ☐ Yes ☐ No
Name Of Patient		Date Of Birth (mm/dd/yyyy)	Gender ☐ Female ☐ Male / Race
Address		Patient Telephone No. ( )	Patient occupation last 2 years
Local Health Department		Public Health Nurse (PHN)	
Telephone No. of PHN ( )		Date Reported to State TB Program (mm/dd/yyyy)	
Name of Primary Physician		Telephone No. ( )	
Name of Other Physician (Pulmonary Specialist, etc.)		Telephone No. ( )	

CHEST X-RAY

Date(s) taken (mm/dd/yyyy) ☐ Normal ☐ Abnormal

Results of X-ray ☐ Cavitation ☐ Infiltrate ☐ Opacity ☐ Granulomas ☐ Nodule

Location ☐ Apex ☐ LUL ☐ RUL ☐ RLL ☐ LLL ☐ LL ☐ RL

Comments:

BACTERIOLOGY

Laboratory where specimen was sent

Specimen Information

		Smear			MTD / PCR			Culture		
Date Collected	Source	POS	Results	NEG	POS	NEG	Comment	POS	NEG	Date Identified
		☐		☐	☐	☐		☐	☐	
		☐		☐	☐	☐		☐	☐	
		☐		☐	☐	☐		☐	☐	
		☐		☐	☐	☐		☐	☐	

Drug Sensitivities

INH	☐ SENS	☐ RES	EMB	☐ SENS	☐ RES
RIF	☐ SENS	☐ RES	OTHER(S)	☐ SENS	☐ RES
PZA	☐ SENS	☐ RES		☐ SENS	☐ RES

TREATMENT

Date Started (mm/dd/yyyy)	Patient's weight		Regimen Duration	DOT ☐ Yes ☐ No If yes, where?	
Drugs	INH	RIF	PZA	EMB	OTHER
Dose(s) and Frequency					

PATIENT HISTORY

Date of PPD (mm/dd/yyyy) — Results (induration) mm

Homeless in the past year? ☐ Yes ☐ No ☐ Unk

Date of Previous PPD (mm/dd/yyyy) — Results (induration) mm

Non-injection drug use within the past year? ☐ Yes ☐ No ☐ Unk

Injection drug use within the past year? ☐ Yes ☐ No ☐ Unk

If previously tested, list city and state

Alcohol use within the past year? ☐ No ☐ Regular ☐ Excess

How much and how often?

If previous PPD was positive, was treatment for TB infection taken? ☐ Yes ☐ No If yes, was treatment completed? ☐ Yes ☐ No

Smoker? ☐ Yes ☐ No If yes, how much and how long?

Patient history of TB disease? ☐ Yes Year (yyyy) ☐ No

Family history of TB disease? ☐ Yes ☐ No

If yes, who and when (yyyy)

Foreign born? ☐ Yes ☐ No If yes, country of origin_____

Month and year arrived in USA_____

Type of VISA ☐ Immigrant / Refugee ☐ Student ☐ Work

☐ Visitor / Tourist

☐ Other Explain_____

Signs and Symptoms ☐ cough ☐ fever ☐ hemoptysis ☐ night sweats ☐ weight loss ☐ loss of appetite

Duration/ dates (mm/dd/yyyy) _____

HIV Status ☐ positive ☐ negative ☐ not tested

Date tested (mm/dd/yyyy)

If not tested, Why? ☐ not offered ☐ refused ☐ other

Recent foreign travel? ☐ Yes ☐ No

If yes, where and when (mm/yyyy)

Other risk factors? ☐ diabetes ☐ kidney disease ☐ liver disease ☐ immunosuppressed ☐ cancer List type_____ ☐ corticosteroid use How much and how long?_____ ☐ other risk factors_____

Resident of long-term care or correctional facility? ☐ Yes ☐ No

If yes, which one and how long?

Disposition ☐ pulmonary ☐ extrapulmonary ☐ not a case

If extrapulmonary, site_____

Case verified by ☐ laboratory ☐ clinical improvement

Instructions for completing
TB SUSPECT CASE DATA

This form is used to gather data on tuberculosis (TB) suspect and confirmed cases. The Department of Health and Family Services requires some of the information in accordance with Wis. Stats. s. 252.05(4) and other data elements are incorporated to assist with TB elimination efforts. Please fill out the form completely and submit it to the Wisconsin TB Program by **fax (608) 266-0049** or by **mail to: TB Program – Division of Public Health, PO Box 2659, Madison WI 53701-2659.**

Local Health Department Contacted (mm/dd/yyyy), Referral Source, Reported to LHD Within 24 Hrs Date the LHD is notified of the suspect (or case) by whom and was the suspect (or case) reported to the LHD within 24 hours of the patient being considered a suspect. Referral source is the person/agency who refers the suspect (or confirmed case) to the LHD.

Wisconsin Administrative Code HFS 145, Appendix A, includes **Tuberculosis** with Category I diseases of "urgent public health importance" that shall be reported **IMMEDIATELY** to the patient's local health officer **upon identification of a case or suspected case**. Once reported to the local health officer, the local health officer is required to notify the State Epidemiologist immediately [HFS 145.04 (4)]

Name of Patient, Date of Birth, Gender, Race, Patient Address and Telephone Number

Name of Local Health Department (LHD), Public Health Nurse, Telephone Number of PHN Put the name of the primary PHN contact and whichever phone number is better for contacting the PHN (LHD or PHN's direct number).

Date Reported to the State TB Program These fields assist in tracking whether reporting time frames are consistent with statutory reporting criteria (see above).

Name of Primary Physician, Telephone Number, Name of Other Physician (Pulmonary Specialist, etc.), Telephone Number

CHEST X-RAY: Record date(s), Results of X-ray, Location Date(s) and specific result(s). Use comment section for results that are not addressed by the boxes.

BACTERIOLOGY: Laboratory where specimen was sent
Indicate all laboratories where the specimens were sent for smear, Mycobacterium Tuberculosis Direct (MTD) / polymerase chain reaction (PCR) and culture results. There is often more than one laboratory involved.

Specimen information - Date Collected, Source, Smear (POS, NEG, Results), MTD/PCR and Culture
For smear results, indicate the amount of AFB seen on positive specimens (e.g. 1-9/field). MTD/PCR note any comments (such as inhibitors, specimen too old, etc.). On the culture, indicate the date the specimen was identified (either as TB or not TB).

Drug Sensitivities For each medication, indicate if the TB isolate is sensitive or resistant to the drug

TREATMENT: Date started (mm/dd/yyyy), DOT, regimen duration, Drugs, Dose(s) and Frequency
Indicate the date the patient began appropriate TB disease treatment, whether or not it was given as directly observed therapy (DOT), and if given via DOT, where DOT occurred (workplace, LHD, home, etc.). Record the initial medication regimen prescribed.

PATIENT HISTORY:
Date of PPD, Results Document current TB skin test (PPD) information in millimeters
Date of Previous PPD, Results Document last known (and documented) previous test date and results
If previously tested, list city and state Document where previous test was given.
If previous PPD was positive, was treatment for latent TB infection (LTBI) taken? If yes, was treatment completed?
Determine if patient with a previous positive skin test took treatment for LTBI and if LTBI treatment was completed.

Signs and Symptoms Indicate which symptoms the patient currently has or has had in relation to their TB suspect case status. Note the duration of the symptoms.

Patient history of TB disease?, Family history of TB disease? Fill in as indicated. Note: history of TB disease, not infection.

HIV status HIV information is requested under the authority of Wis. Stats. s. 250.04 (1). All client information is confidential under Wis. Stat.146.82 (1). Per Centers for Disease Control and Prevention (CDC) protocol all individuals with TB disease should be tested for HIV infection.

Other risk factors? Note other risk factors. If a patient is infected with TB, the risk of TB disease increases with corticosteroid use at high dose for long duration (e.g. >15 mg/day of prednisone (or equivalent) for 1 month or more).

Homeless in the past year? Non-injection drug use within the past year?, Injection drug use within the past year? Alcohol use within the past year? Regular, Excess, Smoker? Fill in per patient and medical history. Re. alcohol use: subjective assessment to guide DOT decision and the recommendations given to physician. ***Regular* alcohol use** indicates baseline and follow-up **liver function tests (LFTs) may be indicated** [2/day – men, 1/day – women]. ***Excess* alcohol use** is an indicator for **DOT** and **LFTs** are indicated to supplement frequent liver symptom monitoring. [Reports intake that exceeds *regular*; diagnosis, hospitalization or treatment for excess alcohol, etc.]

Foreign born?, Month and Year arrived in USA, Type of VISA Document the patient's country of origin and both the **month and year** of their arrival in the USA. Indicate which type of VISA they came on.

Recent foreign travel?, Resident of long-term care or correctional facility? Disposition Fill in as indicated.